Judicialization of the Right to Health and Institutional Changes in Brazil[1]

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Introduction

The judicialization of the right to health in Brazil may be generating institutional innovations in the system. This judicialization has had unexpected effects, such as disrupting budgetary allocations of public healthcare resources. To deal with such effects, many public authorities directly or indirectly involved with the Brazilian Public Health Care System have created a series of institutional innovations. These innovations aim at i) minimizing the budgetary effects of judicialization and/or ii) decreasing litigation involving the public healthcare system. This chapter highlights two demonstrative cases: the healthcare settlement chambers [Câmaras de Conciliação de Litígios de Saúde] and the centers for technical advisement of judges (Núcleo de AssistênciaTécnica - NAT). This chapter provides a description of the centers for technical advisement of judges and show the still preliminary attempts to institutionalize extrajudicial forms of settling healthcare litigation.

We believe that the experiences with conflict resolution and the aforementioned advisement centers illustrate gradual transformations caused by internal institutional factors that may lead – in the medium and long term – to profound modifications in the attributions of different bodies, actually triggering strong innovation.[2] The advisement centers do not decrease the number of cases brought to the Judiciary, but they might alter the outcomes of healthcare claims in the Judiciary reducing its budgetary impacts. The settlement initiatives, on the other hand, have the objective the potential of reducing the number of lawsuits. However, as we show in some initiatives, the settlement arrangement admits the judiciary's direct participation in addressing the claims of those who fail to settle.

[1] The authors would like to thank Thaís Barberino for help with data gathering and research assistance.

[2] K. Thelen, How Institutions Evolve: The Political Economy of Skills in Germany, Britain, the United States and Japan. (Cambridge University Press, 2004), and J. Mahoney and K.Thelen, Explaining Institutional Change: ambiguity, agency, and power. (Cambridge University Press, 2010).

These innovations are still recent and subject to change. Thus, it may too soon to discuss their potential impact. Nevertheless, our conclusion speculates about the possibility of these innovations meeting the goals and objectives for which they were created while creating other problems. In particular, both the extrajudicial settlement experiences and the technical advisement centers operate within Brazil's existing logic of judicialization. This could potentially undermine their capacity to promote medium and long-term changes in the system.

1. The judicialization of healthcare in Brazil

In Brazil, *judicialization of healthcare* is used to decribe the judicial assertion of the constitutional positive right to healthcare by individuals who cannot obtain goods and services from the public healthcare system.[3] In the past ten years the number of these lawsuits in the Supreme Court alone surpassed 3,800 cases.[4]

This level of judicialization of healthcare is only possible because the 1988 Constitution adopted a system of strong judicial review of individual rights. The right to healthcare was initially interpreted by courts as a non-justiciable social right,[5] but such interpretation was later revised by the scholarship and then by courts[6]. In addition to guaranteeing an individual right to health, the Constitution also obliged the state to create and maintain a system of universal healthcare, which was created by federal law no. 8080/1990, and is called SUS (*Sistema Único de Saúde*, or Public Universal Healthcare System). It is meant to offer universal and integral

[3]The judicialization of healthcare in Brazil encompasses mostly supply of drugs – but it pertains also to any goods or services that should be provided by the state, as, for example, hospital beds or medical care.

[4] Data collected by the *Supreme Court in Numbers* project at FGV Law School in Rio de Janeiro shows that, until 2009, 3801 cases concerning court orders for the provision of drugs reached the Supreme Court.. A study funded by the Brazilian Ministry of Justice found 232 Supreme Court rulings on the right to health between January 2009 and August 2010. Ministério da Justiça, Universidade Federal de Minas Gerais, Centro de Estudos Sociais - América Latina, Observatório Da Justiça Brasileira. Observatório do Direito à Saúde: Democracia, Separação de Poderes e o Papel do Judiciário Brasileiro para a Eficácia e Efetividade do Direito à Saúde. Porto Alegre, 2010, p. 13.

[5]This view was represented mainly by famous constitutional scholar José Afonso da Silva, who argued such constitutional norms were of a merely programmatic nature. J. da Silva, Curso de Direito Constitucional Positivo (Malheiros, 1992).

[6]One of theveryfirsttodefendthe justiciability of social rightswas R. Torres, O Mínimo Existencial e os Direitos Fundamentais (Revista de direito da Procuradoria Geral do Estado do Rio de Janeiro. n. 42, 1990). For a comprehensive description of the most commonly used arguments in favor of court-enforceable social rights in Brazil, see SARLET, Ingo W. A Eficácia dos DireitosFundamentaisnaConstituição de 1988. 10a ed. Porto Alegre: Livraria do Advogado, 2010.

assistance, devoid of any kind of discrimination and under "political and administrative decentralization".[7]

SUS is run by the federal, state and municipal governments.[8] Municipalities provide healthcare services, states coordinate healthcare actions, and the federal government regulates and finances the system. SUS was a relevant step in the decentralization of healthcare in Brazil, as it also established the criteria for distribution of federal resources among states and municipalities.[9] In the 1990s, there was further decentralization of healthcare, through the Basic Operating Norms (NOB-SUS, in Portuguese)[10]. Since then, the financial burden of direct provision of healthcare goods and services is largely carried by Brazilian states and municipalities.[11]

Brazil has a pharmaceutical assistance policy as well.[12] The National Medicine Policy (*Política Nacional de Medicamentos*), created in 1998, dictates plans, programs and activities related to pharmaceutical assistance for all levels of government (federal, state and municipal). The Policy came in the wake of a diagnosis of "lopsided medication supply, in the ambulatory level",[13] which was said to negatively impact healthcare outcomes. The Policy's determines that

[7]Article 7 establishes the following principles and guidelines for SUS:
"I – universality of access to healthcare services in all levels of assistance;
II – integrality of assistance, understood as the articulated and continuous group of preventives and healing actions and services, both individual and collective, demanded in each case in all levels of complexity within the system;
III – preservation of people's autonomy in the defense of their physical and moral integrity;
IV – equality of healthcare assistance, without biases or privileges of any kinds;
V – right of the assisted people to information about their health;
VI – dissemination of information regarding the potential of healthcare services and their use by the individual;
VII – employment of epidemiology for the establishment of priorities, the allocation of resources and programmatic orientation;
VIII – community participation;
IX – political-administrative decentralization, with independent administration in each sphere of government."

[8] It should be noted that the Brazilian federal system is made up of the federal government, the states and the municipalities, unlike other federal republics where the federation is composed solely of the federal/central government and the states.

[9]The relevant criteria are demographic and epidemiologic profiles, the healthcare network characteristics, previous technical, economic and financial performances, the levels of participation in the healthcare budget and the existence of a plan for investment and repayment of health services supported by other government entities.

[10]L. Ribeiro. Federalismo, Governo Local e Políticas Sociais no Brasil entre 1996 e 2004 (Editora Fiocruz,Forthcoming).

[11] Towards the end of the 90's and beginning of the 2000's, two developments pointed in the direction of the federal government regaining its capacity to induce the usage of SUS funds: the Strategic Actions and Compensation Fund (*Faec*) and the Basic Operational Norm for Healthcare (*NOAS*). The strong decentralization of public healthcare in Brazil remains, however.

[12]Statute 8080/1990, article 6.

[13]Ministério da Saúde, Política nacional de medicamentos 2001/Ministério da Saúde, Secretaria de Políticas de Saúde, Departamento de Atenção Básica. (Ministério da Saúde, 2001, p 11).

the Minister of Health must continuously update the National Essential Medication List (*Relação Nacional de Medicamentos Essenciais*), which defines which drugs are provided for free in the public healthcare system.[14] These are the ones "considered basic and indispensable for addressing the majority of the population's health problems."[15] The pharmaceutical assistance policy is also decentralized. The National List forms the basis for the organization of the state and municipal lists, which are based on the regional epidemiologic profile. States and municipalities are responsible for financing these drugs and also delivering the medication included in all three lists (national, state and municipal).

It is within this legal framework that the judicial claims for healthcare goods and services gained momentum in Brazil, with a severe impact on Brazilian states and municipalities. Their main characteristics are the following:

- Judicial claims are individual, not collective;
- Most cases request the provision of drugs through SUS;[16]
- Claims have a success rate of 90%;[17]
- Favorable rulings are not based on independent medical assessments, but rather on prescriptions of the plaintiffs' personal physicians. Such prescriptions may contain drugs that have not even been approved for commercialization in Brazil. What is more, a large part of rulings are preliminary injunctions, which require immediate delivery of drugs.[18]

2. Institutional Innovation as a Response to Healthcare Judicialization

In the great majority of cases, the government is forced to comply with court orders even if they are not part of the Administration's plan. This has two effects on the system: the rulings impact on the *allocation of budgetary resources* within the public healthcare system and on *the*

[14] *Idem,* p,12.
[15] *Idem,* p.12
[16] V. Pepe, T. Figuereido, L. Simas, C. Osorto-de-Castro and M. Ventura. "A judicialização da saúde e os novos desafios da gestão da assistência farmacêutica" (Ciência e Saúde Coletiva, 15(5), 2010).
[17] F. Hoffmann and F. Bentes, "Accountability and Social and Economic Rights in Brazil," in V. Gauri and D. Brinks, eds., Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World (Cambridge University Press, 2010)
[18] *Idem*.

management of pharmaceutical assistance itself.[19] Such effects fall mainly on states and municipalities because they are the providers of the main healthcare goods and services ordered by courts. In an attempt to recover control over budgetary spending and management of the pharmaceutical assistance, there have been anecdotal accounts of a wide variety of innovations in Brazil.[20] We discuss in greater detail two innovations that have not been analyzed by the specialized literature so far, and have been implemented in several Brazilian states: the judge technical advisement centers focused on healthcare litigation and some experiences with healthcare extrajudicial settlement.[21]

2.1 Historical Background: the National Judiciary Forum for Healthcare

In 2009, the National Justice Council (*Conselho Nacional de Justiça,* CNJ),[22] an oversight body of the judiciary, created a working group to study and propose concrete responses to the problem associated with healthcare litigation.[23] Based on the work of this group, in 2010, the CNJ advised Brazilian courts to take a series of measures to guide judges in healthcare litigation. [24] One of the main recommendations were partnerships between state courts and

[19]As is the case with the enforcement of any individual negative or positive right. Data on the enforcement of the right to health helps better understand resource allocation issues related to this particular individual right. An interview with the São Paulo state secretary of health, Giovanni Guido Cerri, exemplifies this aspect: according to him, the amount spent on healthcare lawsuits would be enough to build a hospital each month. See http://www.estadao.com.br/noticias/vidae,judicializacao-da-saude-e-uma-distorcao-diz-secretario-,805981,0.htm
See O. Ferraz, "The Right to Health in the Courts of Brazil: Worsening Health Inequities?" (Health and Human Rights Journal 11, no. 2, 2009). According to the Attorney General's Office and the Ministry of Health, in a document titled "Judicial Intervention on Healthcare: A Panorama on the Federal Justice System and Comments on the State Justice System", the Ministry of Health's expenditure with the purchase of drugs, equipment and other materials as a result of lawsuits went from 171 thousand Brazilian Reais on 2003 to 47 million on 2008 and then to nearly 244 million on 2011.

[20] M. Prado, "The Debatable Role of Courts in Brazil's Health Care System: Does Litigation Harm or Help?", (The Journal of Law, Medicine & Ethics Special Issue: SYMPOSIUM: Global Health and the Law Volume 41, Issue 1, 2013).

[21]The CNJ has recently begun discussing the implementation of a new institutional alternative: the establishment of specialized courts for healthcare in Brazil. A special court for healthcare was set up in Rio Grande do Sul and, according to reports from the state Judiciary, has contributed for the decrease in healthcare judicialization in the state.See http://blogdofred.blogfolha.uol.com.br/2013/05/28/vara-especializada-em-saude-exemplo-gaucho/.

[22] The National Justice Council was created by the Constitutional Amendment no. 45 in December 30th, 2004 and began its activities on June 14th, 2005. The CNJ's main goal is to control the administrative and financial management of the Judiciary branch and the compliance of judges' professional duties. Onthe CNJ, seeL. Ribeiro andC. Paula. Conselho Nacional de Justiça (Dicionário Histórico Biográfico Brasileiro, FGV, 2010).

[23] Decree 650/09. The decree itself came as a result of a public hearing organized by the Supreme Court on May, 2009, in which over 50 specialists – lawyers, public defenders, prosecutors, judges, professors, doctors, health technicians, SUS managers and users – discussed issues related to the right to health in Brazil, identifying one of the core problems as the elevated number of suits filed in the country.

[24] The National Justice Council was created by the Constitutional Amendment no. 45 in December 30th, 2004 and began its activities on June 14th, 2005. The CNJ's main goal is to control the administrative and financial

doctors or healthcare professionals to provide judges with technical support to decide the cases. In addition, CNJ also recommended that judges make an effort to base their sentences on medical reports that describe the patient's disease and indicate the needed drugs,[25] "with generic denomination or the active principle, products, orthoses, prosthetics and general supplies accompanied by the exact posology" and avoid granting drugs unregistered at ANVISA (the Brazilian regulatory agency for sanitation), "except in situations provided for in the law". The Recommendation urged judges to consult public healthcare system managers before granting injunctions.[26]

In 2010 the CNJ also created the National Judiciary Forum for Healthcare – also called the Healthcare Forum.[27] Its main objective is to monitor and propose alternatives to minimize the negative effects of judicialization.[28] On November, 2010, the Forum recommended that State Executive Committees be created.[29] Those Committees present a bi-annual activities program proposing measures for the prevention and solution of lawsuits. In June, 2011, the State Committees recommended that the state and federal regional courts should enable doctors and pharmacists to provide judges with technical support in their rulings. CNJ embraced the

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management of the Judiciary branch and the compliance of judges' professional duties. Onthe CNJ, seeL. Ribeiro andC. Paula. Conselho Nacional de Justiça (Dicionário Histórico Biográfico Brasileiro, FGV, 2010).

[25] Instead of issuing rulings unsupported bysound medical opinions.

[26]The other proposed measures were that judges "verify with the National Research Ethics Commission (CONEP), if the plaintiffs are part of drugs laboratories' experimental research programs, in which case the laboratories must take over the continuation of treatment"; "determine, when deciding whether to grant injunctions in the context of existing public policies, that the beneficiary be registered in the respective programs"; "include health law legislation as an independent subject in the Administrative Law program of the public tests for becoming a judge, in accordance with the mandatory subjects list established by resolution no. 75/2009 of the CNJ"; "promote, for purposes of practical operational knowledge, visitation of judges to the Municipal and state health councils, as well as to public healthcare units or those affiliated with SUS, medication allowance facilities and hospitals with cancer treatment facilities".

[27] It comprises a National Executive Committee, representatives of the state healthcare committees – which, in turn, are made up of judges and judicial public servants of the state courts – and the judicial branch, the Public Prosecutor's Office, the Public Defender's Office, the Ministry of Health, and state and municipal health officials. Health law researchers and civil society are also part of the Forum.

[28]Art. 2 of resolution no. 107. The resolution thus places under the Forum's responsibilities: i) the proposition of solutions to improve lawsuits related to healthcare assistance, including the supply of drugs and other products in general, treatments and access to hospital beds and ii) the monitoring of lawsuits related to SUS. Also, the Forum must actively propose i) measures aimed at optimizing judicial routines, at organizing and structuring specialized judiciary units and ii) measures aimed at preventing healthcare lawsuits. In addition, the Forum must study and propose whatever other measures that can be considered pertinent to the fulfillment of its objectives.

[29] These are formed by a member of the Public Prosecutor's Office (Federal or State), a member of the Public Defender's Office (Federal or State) or of the Brazilian Bar Association, an administrator and a healthcare specialist.

recommendation[30] and also directed courts to advise their judges to contact, when possible, the Health Regulatory Agencies (ANS and ANVISA),[31] the Federal Medicine Council (CFM) and the Federal Odontology Council (CFO) so that these institutions can – within their fields of expertise – issue opinions on the plaintiffs' claims (e.g. drugs, materials, orthoses, prosthetics and experimental treatments). The State Committees also proposed the creation of a "Technical Center for the Support of Judges", based on the Rio de Janeiro experience.[32]

In 2011, the Forum recommended that courts interact with other stakeholders to avoid the judicialization of healthcare (e.g. adopting orientation guidelines to legal and medical professionals, instituting mediation and settlement chambers). The Forum also recommended that courts support previous decisions via dissemination of best practices and for the creation of Executive branch departments to assist judges with technical/medical information.

It is out of these recommendations that the two innovations described below are born.

2.2 Center for Technical Support in Healthcare Lawsuits (NAT)

As we previously pointed out, the CNJ and the Healthcare Forum recommended the creation of arrangements to provide technical information to help judges' decision-making processes due to the increasing volume of healthcare lawsuits – in other words, the judicialization phenomenon.[33]

These recommendations were inspired by the pioneering experience of the Center for Technical Support in Healthcare Lawsuits in the state of Rio de Janeiro (NAT). NAT started in 2009 as a partnership between the state of Rio de Janeiro health ministry (SES/RJ) and the Rio de Janeiro state appellate court (TJ/RJ) with the goal of assisting judges in the following healthcare lawsuits: requests for drugs, dietary supplements, healthcare material, orthoses,

[30] CNJ's recommendation no. 36.
[31] For a detailed description, see chapter 8 in this volume.
[32] *Technical centers for the support of judges – National Committee suggestion*.5th recommendation, Official Document for the 1st Meeting of the National Judiciary Forum for Healthcare.Brasília, 2011.Available at http://www.cnj.jus.br/images/programas/forumdasaude/recomendacoes_do_I_encontro_de_saude.pdf.
[33] Recommendation 31, 2010 ("state appellate courts and regional federal courts should propose agreements aimed at making available technical support by a doctor and pharmacists to aid judges in making evaluations of the medical matters described by parties in healthcare lawsuits, observing regional peculiarities."). In 2011, this recommendation was reiterated by the National Health Forum, which specifically suggested the creation of *technical centers for the support of judges*, with an institutional format similar to that of the one in the state of Rio de Janeiro. See note 9, supra.

prosthetics and medical treatment. NAT is under the umbrella of the SES/RJ's legal counsel and the TJ/RJ's chief judge's department for evaluation and special projects (DEAP). As a department created by a partnership between two branches -- the state Executive and the Judiciary -- NAT works with an organizational structure that complies with formal and informal norms, rules and procedures of both. NAT is currently composed of a general manager and four employees, a crew of assistants coordinated by a doctor and two pharmacists, and a technical core made up of nine pharmacists, three nurses and three nutritionists. The reports issued by NAT merely provides judges with technical information.

The CNJ and Healthcare Forum recommendations reflect an understanding that the NAT is an *institutional solution* apt to rationalize judicial decisions related to healthcare services. Several Brazilian states have been setting up NAT-inspired departments to assist judges in healthcare lawsuits. Examples include judicial healthcare workgroups at the Bahia state court and assistance centers in the states of Bahia, Mato Grosso, Minas Gerais, Piauí, Pernambuco and Espírito Santo. Also, there are proposals for launching similar support centers in several other Brazilian states. The table below provides a comparison of such initiatives.

Quadro1
Center for Technical Support in Healthcare Lawsuits(NAT)

Year	State	Stakeholders	Objectives
2011	MatoGrosso do Sul	State court, state healthcare ministry, Campo Grande (capital) municipal healthcare department	Establishment of Technical Healthcare Center to assist judges in their decisions concerning the provision of drugs, exams, hospitalizations, clinical and surgical treatments. The center is run by two doctors, two pharmacists, a nurse and a court servant.
2012	Pernambuco	State court, state healthcare ministry	Establishment of NAT-Pernambuco.The center is operated by an orthopedist and four pharmacists. It can be called to action by judges in cases where they see fit, especially in order to obtain clarifications on medical and pharmaceutical issues and technical information on the requested drug. According to the Pernambuco state healthcare ministry, 943 medication request lawsuits were filed in 2011.
2012	Espírito Santo	State court, state healthcare ministry.	Follows the same guidelines and principles of technical assistance to judges, especially with drug request lawsuits. These have increased from 487 on 2009 to 587 on 2010.

2012	Minas Gerais	State court, state healthcare ministry	The ministry has vowed to provide information directly to judges regarding drugs, exams and medical treatments in general with the objective of assisting them in decision-making.
2012	Acre	State court, state healthcare ministry	The agreement stipulates that experienced SUS technicians will provide technical information regarding drugs, exams, hospitalizations and medical treatments, whenever required by judges, and also by public prosecutors and public defenders.

NAT is not only being mimicked in other states but its tasks are being broadened as well. For example, since February 2012, NAT has been assisting the federal courts in Rio de Janeiro, in addition to the state courts. There are also projects for cooperation between NAT and the state and federal Public Defender's Office in Rio de Janeiro. As it was initially set up to assist state judges, NAT has slowly increased its reach due to demand for its services by the institutions mentioned above.

2.3 Proposals for Extrajudicial Settlements

The state of Rio de Janeiro is about to create the Healthcare Litigation Settlement Chamber to deliver an extrajudicial solution for healthcare litigation. This is a partnership between the state and federal Public Defender's Office, the State Attorney of Rio de Janeiro, the state healthcare ministry, the municipal Attorney for the city of Rio de Janeiro, the municipal healthcare and civil defense department, and the state court of Rio de Janeiro. These institutions signed the Chamber's constitutive agreement in June, 2012 and, according to information issued by the press, it was an initiative of the state Chief Public Prosecutor and the state court. Its objective is to "'unjudicialize' some of the matters and transport these claims to an administrative solution, untying the bureaucracy and speeding up the solution to the problems of our clients."[34] How effectively it will perform this function, remains to be seen.

In this case, Rio de Janeiro is following an innovation pioneered in another Brazilian state (Rio Grande do Norte), called "Mediated SUS". The program started when the state Secretary of Public Health, the state Public Defender's office and the state and federal Attorney's

[34] http://www.dpu.gov.br/index.php?option=com_content&view=article&id=8597&catid=79&Itemid=220)

offices agreed to create extrajudicial mechanisms for addressing healthcare issues such as access to medication.[35]

3. Theoretical Implications of the Cases of Institutional Innovation in Brazil

These cases illustrate a key aspect of healthcare judicialization in Brazil: its indirect effect on judicial institutions. While a large part of the literature on healthcare judicialization concentrates on litigation as an instrument of social change and political reform in healthcare, Prado (2013) focuses on the indirect effects of judicialization on the healthcare system and on other institutions such as, for example, the Judiciary. The author correlates this concern with a broader question on institutional change. To the extent that institutions in general are resistant to change, Prado asks whether healthcare judicialization might have *"the potential to destabilize a path-dependence system, where formal and informal institutions become self-re-enforceable and are likely to remain in place for an extended period, despite being dysfunctional"*[36]. She hypothesizes that healthcare judicialization in Brazil could potentially have the following effects: promote isolated political transformations in the healthcare system; spur institutional changes on the healthcare system; and, lastly, induce institutional changes outside the healthcare system. The third type of change refers to transformations on entities that do not belong to the healthcare system. Prado specifically highlights changes that judicialization could cause to the Judiciary.

Building up from these hypotheses, we can consider the institutional meaning of the creation of the Healthcare Forum, the NAT and some other extrajudicial settlement experiences as reactions to the healthcare judicialization.

1) The innovations described here do not seem to reveal an impact of healthcare judicialization over isolated policies within the healthcare system.

2) These innovations have an effect on healthcare system institutions. First, as courts set out to collaborate with other institutions that participate directly in the healthcare system, such as state healthcare ministries, for example, a new institution is created within this system. This is the case with NATs, the hybrid institutional system developed to assist judges with their rulings on healthcare. The problem is that NAT does not change how the healthcare system operates in providing its services. Thus, the second hypothesis may be more clearly

[35] See http://www.saude.rn.gov.br/content/aplicacao/sesap/imprensa/enviados/noticia_detalhe.asp?nImprensa=0&nCodigoNoticia=33767

[36] M. Prado, 2013, note 23, supra, p. 3.

illustrated by the case of the extrajudicial settlement initiatives – in which the Judiciary will be incorporated into an administrative decision-making structure of the public healthcare system. Should these experiences proliferate and become relevant, a new institutional solution to solve disputes – that is not fully administrative nor fully judicial -- will be spawned in the health care system of Brazil.

3) These innovations seem to indicate a change in the judicial procedures related to petitions for healthcare goods and services within the Judiciary itself. However, this is not a direct change as the examples provided by Prado, that is, a – superior – court ordering that judicial procedures be changed. Instead, the innovations were recommended by CNJ and adopted by courts voluntarily. However, the implementation of NAT means the adoption of new procedures inside the courts whereby judges start to be advised and rulings start to be influenced by a technical report issued regularly and systematically by the staff of a healthcare ministry. Adherence to this practice could cause significant changes in court order dynamics. Such changes might in turn effect substantive transformations as well.[37]

While the hypotheses provided by Prado allow us to classify the observable changes that have occurred so far in the system, there may be further changes yet to be analyzed, as we describe below.

3.1 Changes

These new spaces for decision-making and dialogue among stakeholders – the establishment and institutionalization of the technical advisement centers and the yet emerging extrajudicial settlement experiences– reflect a process of institutional change that could

[37] The judicialization of the right to healthcare can also affect the relationship between the Executive and the Judiciary. See V. Oliveira e L Noronha. Judiciary-Executive Relations in Policy Making: the case of drug distribution in the state of São Paulo. (Brazilian Political Science Review, 2012). The authors performed empirical research of the São Paulo State Healthcare Department documents and of Supreme Court and CNJ rulings and came to the conclusion that the relationship between the Judiciary and the Executive is at first confrontational, but later becomes complementary: "The Executive responded to judicial activism by creating more efficient policies and providing more access to medication for its citizens; the Judiciary keeps pushing for the distributions of new medications and medical supplies, but now it pays more attention to technical issues argued for by the Executive's administrators (...)" V. Oliveira and L Noronha. Judiciary-Executive Relations in Policy Making: the case of drug distribution in the state of São Paulo. (Brazilian Political Science Review, 2012, at 33-4).

potentially have broader effects than the ones observed so far. These experiences could thus make for interesting cases to be used in analyzing the broader process of institutional change and innovation.

The literature on institutional change has been enriched with new formulations about the processes whereby gradual modifications of institutions are implemented over time. As Mahoney and Thelen (2010) alert in an article dedicated to the theory of gradual institutional change, the specialized literature deploys theories to explain why several kinds of basic institutional configurations appear in certain cases and on certain times and why specific institutions are terminated and replaced with others. But the literature remains shallow when it comes to theories that explain the gradual development of existing institutions. Instead the literature has focused mostly on change caused by external factors, based on the premise that institutions dispose of strong reproduction mechanisms, which would encumber or make difficult changes provoked by factors endogenous to the institutions.[38]

One of the main factors explaining the resilience of institutions is the legacy of their own results. Thus, for example, studies on social welfare policies show that left-wing parties were fundamental for the establishment of universal social assistance policies. Such policies, once put in place, become a focal point of political dispute, but hardly ever suffer restrictions –even in center or right-wing governments – due to their electoral appeal and pressure by their beneficiaries[39]. Overall, the legacy created by institutions affects the preferences of those playing a role within them, gelling outgoing interests and the opportunity structure of these players' actions (what they can do, when and how), consolidating an action structure composed both of *points* and *players* with veto over changes.[40] Therefore, to some authors, regardless of the motivations of political players, institutional changes tend to be *incremental*. Even if formal changes are rare, this doesn't mean that institution would suffer internal modifications over time.[41] To other authors, changes wouldn't even be gradual, rather they would constitute sporadic events generated by external factors or critical events. According to this view, deeper

[38] P. Pierson. Politics in Time: history, institutions, and social analysis (Princeton University Press, 2004).
[39] See E. Huber and J. Stephens, Development and Crisis of the Welfare State: parties and policies in global markets (The University of Chicago Press, 2001), and P. Pierson, Dismantling the Welfare State?: Reagan, Thatcher and the Politics of Retrenchment (Cambridge Studies in Comparative Politics, 1995).
[40] See G. Tsebelis, Veto Players: How Political Institutions Work (Princeton Universtity Press, 2002), and E. Immergut, Institutional Constraints on Policy, (in: Moran, Michel/Rein, Martin/Goodin, Robert. E., The Oxford Handbook of Public Policy, Oxford: Oxford University Press, 2006). According to Tsebelis classic definition a player is a veto player if its agreement is a requirement for a change in the *status quo*.
[41] F Baumgartner and B. Jones, Agendas and Instability in American Politics, (Chicago University Press, 2009).

institutional changes would be explained predominantly by external factors and would hardly or never at all be caused by "inside" players[42].

Considering the empirical evidence on institutional change and with the aforementioned institutional debate in mind, Thelen (2004) suggests that a) in many cases, institutions are resistant even to external changes; that is, jolts fail to stimulate innovation in certain situations and that b) gradual changes caused by internal factors in the institutional structure may lead, on the medium and long term to profound alterations in the attributions of institutions, provoking actual substantial innovation. For the author, what is surprising about institutions is that over time they seem to change both a lot *and* very little. This apparent contradiction may be explained by the fact that institutions are formally resilient over time, but their attributions, the players that take part on them, or even the beliefs and conceptions about what they should do, actually change, along with all the kind of social, political, cultural change that certain communities are subject to.

With this perspective in mind, Thelen (2004) posits that the analysis of institutional change fall on the causal mechanisms that produce it. This, in turn, directs analysis to the action and interaction of relevant players inside institutions. We thus notice an effort by this literature to overcome the institutional innovation *versus* institutional reproduction dichotomy, focusing on institutional persistence in the face of external shocks and institutional change within institutions themselves. In order to put aside this opposition, Thelen emphasizes the possibility of crises or "*turning points*" being endogenously generated and invites us to ponder the ways by which new problems and solutions that present themselves to relevant players within a certain institutional framework as products of the past and not as historical accidents. Her proposition is that institutions be conceived not only as restrictions to the engagements of relevant players, but rather also as strategic resources that may be mobilized by them as answers to changes in the social, economic and political context.

Analytically, as she attempts to overcome the innovation-reproduction contrast, Thelen introduces a conception of institutional change through *layering* and *conversion*. The first case – layering – involves, on the part of relevant players, the renegotiation of some elements of a group of institutions. This might occur in contexts where, faced with lack of support to radically alter or

[42] D Diermeier and K. Krehbiel, "Institutionalism as a Methodology", Journal of Theoretical Politics, 2003).

substitute a particular institution, certain players begin to negotiate with opposing players to add new institutions to the existing arrangement as a solution to an emerging problem. The "innovators" thus accommodate to the pre-existing structures and practices. *Conversion* means the process by means of which institutions designated to certain objectives are used for other purposes. These concepts are useful to describe the changes observed in Brazil. The experiences proposed by the Healthcare Forum and, up until now, the one with the NATs seem to be both institutional change through *layering* – e.g. the new spaces created within the Judiciary –and through *conversion* – e.g. the Judiciary performing a role in extrajudicial settlements. Healthcare judicialization appears, therefore, to have induced endogenous changes in the sense indicated by the literature.

Once we have classified these changes as such, and with the academic discussion on institutional change in mind, we can speculate that the process of healthcare judicialization in Brazil may propel further changes in the institutional framework of the healthcare system. As we pointed out before, the Judiciary could, using the initiatives proposed at the Healthcare Forum and implemented in the existing NAT and extrajudicial settlement experiences, modify the structure of the provision of healthcare goods and services. This is due either to the direct entrance of a new player in decision-making – the Judiciary – or, since new avenues for interactions are set up, to the interactions between healthcare players. The long-term effects of such participation and of the interactions that may arise between them could greatly alter the institutional arrangement of Brazil's healthcare system.

Literature on institutional change by endogenous factors suggests that the focus of analysis be directed to the action and interaction of players internal to the institutions. The analytical model to explain public policy decisions can take into account 1) the rationality model involved: whether limited rationality (due to lack of information) or not; and 2) the decision-making context, whether ambiguous (marked by ambivalence; several possible ways to make a decision) or not[43]. According to the classification of the rationality model and that of the action context, the theoretical approach to understanding the process for choosing public policy alternatives (or institutional alternatives) can be based on the rational school (the player has

[43] See N. Zahariadis, "Comparing Three Lenses, of Policy Choice" (Policy Studies Journal, Vol. 26, Issue 3, 1998).

information to guide his actions and the context isn't one of ambiguity) or on other models when rationality is limited and there is indeed ambiguity in the context of decision-making[44].

An interesting fact is that the choice of an institutional alternative can be marked by limited rationality in a context of ambiguity, but its institutionalization might lead to overcoming the limitation as well as the ambiguity. This means that the action, interaction and strategy of players that participate in the creation and institutionalization of an innovation may transform itself over time, suggesting that the endogenous factors for explaining the transformation are themselves variable, according to specific phases of institutional change. To what extent these theoretical propositions occurred with the creation process of the NATs and the extrajudicial settlement experiences remains to be explored.

3.2 Persistence

Although the initiatives proposed and implemented by the Judiciary to deflect the unwanted effects of healthcare judicialization – especially over the planned healthcare budget itself and the management of pharmaceutical assistance – seem to indicate a change in the institutional arrangement of the public healthcare system, a core characteristic of healthcare goods and services provision appears to linger on and even strengthen itself: the logic of judicialization.

This logic is seemingly present in all proposed and implemented initiatives described in the second section of this chapter. In the case of NATs, the officially stated objective isn't to stop or even reduce the amount of healthcare lawsuits – even though a decrease in the number of successful plaintiffs would possibly discourage other people from going to court. In the case of extrajudicial settlement experiences planned by the Judiciary an intriguing effect could come into play: a sort of "contamination" of this process by the judicialized behavior of the entities involved in it.

Such "contamination" could be deduced and adapted from a definition of judicialization postulated by Tate and Valinder (1995) in a book dedicated to the analysis of the Judiciary's

[44] Basically, in this case the literature points to the use of Kingdom's "multiple flux model". J. Kingdom, Agendas, Alternatives, and Public Policies (Addison-Wesley Educational Publisher, 1995).

expansion in several countries that became a relevant reference on the subject.[45] The authors divide analytically the concept of judicialization – in this case, the judicialization of politics, which refers to 1) a "more dramatic" transference phenomenon: normative decisions by the legislator or the Administration flow to the Judiciary, something that occurs mainly by means of constitutional review mechanisms; and 2) a "less dramatic" phenomenon whereby decision-making and conflict resolution methods akin to courts are incorporated by different administrative departments. This second possible meaning of judicialization is the one we find relevant here.

What we observe in Brazil is the incorporation of judicial methods and procedures in order to solve conflicts of interest, with the risk, should these methods and procedures not be followed, of a lawsuit being filed with a claim for healthcare benefits. In other words, not only is the Judiciary directly playing a role in extrajudicial conflict solving, but its *modus operandi* casts a shadow over the other players. It seems that despite the desire of federal, state and municipal governments to tourniquet the budget bleeding of healthcare judicialization, efforts to that effect have had a catch-22 role of making the judicialization logic even more pervasive.

Conclusion

The current institutional environment in the context of Brazilian healthcare provision is very peculiar: the full justiciability of the individual right to health has prompted the Judiciary and the Executive branches to adapt to the new phenomena of high volume of litigation with significant impacts on judicial practice and state budget management.

The analysis of innovations implemented in response to this has showed that different elements of the current institutional theory must be borrowed from different theories, creating a puzzle that doesn't necessarily present uniformity. Institutional change in the Executive and the Judiciary have caused existing departments to adapt and new ones to emerge. Persistence, on the other hand, has meant that the judicialization logic is embedded the new institutional configuration. We hope to have shown, above all, that healthcare judicialization in Brazil and its institutional reactions point to the need for new developments on institutional design literature.

[45] C. Neal Tate and T. Vallinder, The Global Expansion of Judicial Power, (New York University Press, 1995).